TOWNSVILLE PERIODONTICS & DENTAL IMPLANTS

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In order to appropriately look after your needs, please review and complete the following questionnaire.
Your information will be treated with strict confidentiality.

Medical History Questionnaire

Title (Please Circle): Mr Mrs Ms Miss Dr Other: **Date of Birth:**

Last Name: **First name:**

Postal Address:

Post Code:

Telephone (Home): **(Work):** **(Mobile):**

Email Address:

Occupation: **Employer:**

Emergency contact (Name): **Relationship:** **Phone No:**

Who referred you to/how did you find our practice:.

Do you have private Dental Insurance? YES / NO If so, which fund?:

Confidential Medical History:

Have you ever had **any** of the following? Please tick those that apply to your medical history:

- ❑ AIDS/HIV Exposure
- ❑ Asthma
- ❑ Blood Disease
- ❑ Bone Disease
- ❑ Cancer
- ❑ Chemotherapy or Radiotherapy
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Heart Disease
- ❑ Heart Valve Defect
- ❑ Hepatitis A, B, C, D or E
- ❑ High Blood Pressure
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Mental/Nervous Disorder
- ❑ Organ transplant
- ❑ Pregnant? Date due_____
- ❑ Prosthetic Joints
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sinus problems
- ❑ Skin Problems/Rashes
- ❑ Stroke
- ❑ Thyroid Problems
- ❑ Ulcers

OTHER: (Any clarifications or other conditions):_____

Is **Stress** a significant part of your life? YES / NO

Do you have a medical condition which requires **ANTIBIOTIC COVER** prior to dental treatment? YES / NO

ALLERGIES: (eg Antibiotics, Latex, Other): _____

SMOKING STATUS: (Please tick)

- ☐ Never
- ☐ Current ---------> How many cigarettes per day? _____ For how many years? _____
- ☐ Past ---------> How many years did you smoke for? _____
  How many cigarettes per day? _____
  When did you quit? _____

Are you currently taking **any** medications? YES / NO If so, please list? (incl. Aspirin, Contraceptive Pill, Osteoporosis medication):

_____

_____

Name of GP: _____ Name of Specialist (if applicable) _____

CONTINUES OVER.....

Dental History:

Approximate date of last dental visit: _____ Reason for visit: _____

How often do you clean your teeth: _____

What do you use to do this: (circle) Manual toothbrush Electric toothbrush Floss Flossettes
Interdental brush Interdens/Toothpicks Waterpik Other

Have you ever had any complications following dental treatment? YES / NO

If yes, please describe: _____

How anxious are you about dental treatment? (circle)

Completely comfortable Completely terrified

1 2 3 4 5 6 7 8 9 10

Have you ever had any of the following?	**Yes**	**No**
Previous treatment for gum disease?	❑	❑
Does floss tear between your teeth?	❑	❑
Does food get jammed between your teeth?	❑	❑
Do you think you have occasional bad breath?	❑	❑
Do you have any family members with gum disease?	❑	❑
Have you ever experienced difficulty with adequate anaesthesia (numbness) when at the dentist?	❑	❑

Declaration and Consent: **Please read carefully and sign.**

1. I declare that the above information is true and correct to the best of my knowledge. If there are any changes to my medical history, I will notify the treating clinician as soon as possible.
2. I authorise the doctor or designated staff to undertake examination, x-rays, study models, photographs and other diagnostic aids as deemed appropriate in order to make a thorough diagnosis. Any associated fees will be discussed beforehand.
3. Upon such diagnosis, I authorise the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
4. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks.
5. I understand that the time set aside for my appointment is important, and I make a commitment to maintain these appointments once made. I understand that failure to provide the practice with ***at least 48 hours notice*** of appointment changes or cancellation may elicit a broken appointment fee.
6. I agree to be responsible for payment of all services rendered on my behalf and on behalf of my dependants. ***I understand that payment is due at the time of service*** unless other arrangements have been made and agreed upon mutually. Payment can be made by way of: cash, cheque, EFTPOS, credit card (VISA or Mastercard only). If payment is made via cheque then a photocopy of a valid Driver's Licence will be required.

Patient's or guardian's signature: _____ Date: ____/____/____

Parent or guardian's name (if applicable): _____

Thank you for your assistance.